MOUNTAIN LAKE SERVICES
ESSEX COUNTY CHAPTER, NYSARC, INC.
10 ST. PATRICK'S PLACE, PORT HENRY

QUALITY IMPROVEMENT PLAN
APRIL 2025

UPDATE 8/9/23; 3/29/2024; 4/25/25
BOARD APPROVAL DATE: 5/16/25

I. INTRODUCTION

Mountain Lake Services strives for excellence in management and in support services for people with intellectual and other developmental disabilities and upholds common standards and expectations to promote the well-being of those we support to assure those individuals and their families of our common commitment to our mission.

Mountain Lake Services' mission is to partner with people of all abilities to live their very best lives. Mountain Lake Services is committed to continuous quality improvement that is supported by policies and procedures.

The Quality Improvement Plan addresses the annual collection and review of data along with identifying areas for improvement. An annual analysis of the data will determine if revision of the Plan is necessary. The Plan itself should be updated yearly with Board review. The Quality Improvement Plan reflects consideration for achieving the following outcomes:

- Individualized supports, planning and service delivery
- Protections, health and safety, rights and environmental supports
- Support of family/natural supports and community connections/inclusion
- Workforce performance
- Continuous quality improvement
- Governance and leadership

II. KEY QUALITY INDICATORS

As part of the improvement process, Mountain Lake Services shall focus on nine areas listed below that require immediate focus and attention to achieve improvement. Key Indicators, relating to the current *Mission Statement* of Mountain Lake Services, include the following items:

1. Bureau of Program Certification Reviews (including the number of reviews and the number of deficiencies)
    - Statements of Deficiency
    - Exit Conference Deficiencies
    - Recommendations
    - Best Practices
    - Plans of Corrective Action

- Report on plan approval and need for additional improvement

2. Mountain Lake Services' Incident Review Committee's Quarterly *Report*
    - Trends (include proactive measures as part of this process)
    - Recommendations for action and plan of correction

3. Quality Improvement Reviews by Non-regulatory Agencies (Example: CQL Accreditation Reviews)

4. Self-Audits:

    Based on assessment of risk and need, Mountain Lake Services' Quality Improvement staff shall conduct audits on a sample of programs identified as high risk using OPWDD re-certification checklists and related guidance. This self-survey information will be reported to Mountain Lake Services' Executive Management Team and summaries of findings reviewed regularly with the Board of Directors. Quality Improvement staff shall develop and maintain auditing schedules, identifying risk, sampling and protocols, as outlined in the *Quality Improvement Plan*.

5. Satisfactions Levels of the People We Support

    Questionnaires/surveys shall be completed, with results compiled, reviewed and utilized for improvement. People we support, their family members and advocates shall be provided with contact information on appropriate agency staff/board members for conveying complaints and/or concerns.

6. Satisfaction Levels of Our Staff

    Questionnaires/surveys shall be completed, with results compiled, reviewed and utilized for improvement.

7. An Assessment of the Quality of Life of the People We Support

    More in depth than a satisfaction survey and emphasizing the CQL Personal Outcome Measures (POM), Mountain Lake Services shall describe how the needs, strengths, interests and aspirations of the person are being met through individualized supports, as well as individual satisfaction with services. The person's input will be included in the self-survey process.

8. Human Resource Issues such as Staff Retention Rates, OSHA Reportable Injuries, Adequacy of Staffing Levels and Staff Development Programs

9. Board Governance and Review with Attestation of *Quality Improvement Plan*:

    - Board review of the Mountain Lake Services' programs and services to ensure conformity with our *Mission Statement*.
    - Board participation on the Incident Review Committee, the standing committee for review of incidents.
    - Board visits to program sites, according to its guidelines for announced and unannounced visits.
    - Board analysis of Mountain Lake Services' self-surveys and regulatory surveys to identify agency or program specific trends.
    - Board awareness of State or Federal regulatory authorities' communications, regarding deficiencies in any agency program or operation.

- Board assurance that the Executive Management Team has the means to continually assess the adequacy of staffing levels, staff competence and staff performance with a mechanism to address deficiencies.
- Board assurance that the Mountain Lake Services has a plan for ongoing staff development and training.
- Board assurance that expectations for ethical conduct be communicated and reinforced for all Mountain Lake Services' employees, volunteers and Board members.
- Board assurance that Mountain Lake Services' practices will encourage the development and expression of self-advocacy by the people receiving supports and services; and assurance that a process is in place for self-advocates to provide input to the agency, regarding practices and governance.

III. Activities to Achieve the Key Quality Indicators

1. Bureau of Program Certification Reviews

Statements of Deficiency (often referred to as SOD) are issued by OPWDD following a site survey in which there is at least one significant deficiency noted during the survey process. This may relate to areas such as fire safety, medication administration, health services, nutrition, physical plant, personal allowance, habilitation, etc. In some cases, OPWDD will only make recommendations that do not rise to the level in which they issue an SOD. Other, more serious deficiencies will result in the issuance of a 45/60 day letter. These "letters" are issued by OPWDD when very serious site specific or system issues are identified in a survey and/or the services provided are unsatisfactory and may affect the health or safety of the program participants. These "letters," also sent by OPWDD to each member of the Board of Directors, require immediate action and correction. Without satisfactory response, OPWDD may close the program or transfer the auspices to another organization. When the organization receives the SOD, the appropriate program staff develops a *Plan of Corrective Action* (POCA). This plan addresses the specific matter identified by the citation, as well as incorporates a systemic correction that may be necessary within the site or related programs.

Mountain Lake Services' Director of Quality and Training, who oversees Quality and Training staff, shall oversee and coordinate all OPWDD Bureau of Program Certification activities and responses, including:

- Ensure that OPWDD survey teams have access to the information and access to the sites that they need and will assist the survey team during its reviews.
- For all certification reviews that result in a *Statement of Deficiencies*, the Director of Quality and Training shall coordinate a comprehensive *Plan of Corrective Action* (POCA); and communicate such findings to the Executive Management Team and the Executive Management Team. POCAs shall be pre-approved by the Executive Director or designee, prior to sending to the regulatory agency.
- Ensure that all SODs that result in a 45 / 60-day letter are promptly communicated to NYSARC State Office.
- Maintain, aggregate, and analyze data on the OPWDD surveys.
- Share survey data with the Executive Management Team and NYSARC annually, as outlined in the *NYSARC Quality Data Reporting Form*.

The following are steps that Mountain Lake Services will take when certification reviews result in a Statement of Deficiency:

- The (Senior) Director of the program working in conjunction with clinical or support departments, will draft a Plan of Corrective Action to address the immediate, monitoring and systematic responses
- The Compliance Officer, or designee will review the Plan of Corrective Action and provide feedback to the (Senior) Director
- The Compliance Officer will submit the Plan of Corrective Action to the Executive Director
- The Executive Director will review the Plan of Corrective Action and once any suggested revisions are completed, Compliance Officer will submit to OPWDD for approval.
- Once approved by OPWDD, Mountain Lake Services staff will work towards ensuring that all items on the Plan of Corrective Action are completed within the appropriate timeframe.

In addition, even when a certification review results in verbal recommendations or exit conference deficiencies, Mountain Lake Services will complete an internal plan to assist in ensuring that these deficiencies are not repeated.

Information related to BPC surveys and the findings are shared at leadership meetings, to the Quality Improvement Committee and the Board of Directors on at least a quarterly basis.

The Director of Quality and Training/Compliance Officer will maintain, aggregate and analyze the data on the OPWDD surveys and report out to the Quality Improvement Committee and the Board of Directors on at least an annual basis. This information is used as part of analyzing risk areas for the agency and a focus for self-surveys or compliance auditing. The Quality Improvement Committee and Board of Directors will also be informed of all outstanding verifications for each active Plan of Correction.

The goal in this area is to decrease the overall number of Statements of Deficiencies received as well as to decrease the number of deficiencies received on Exit Conference Forms. In 2024 Mountain Lake Services received 4 Statements of Deficiency (4.4% of total BPC surveys in 2024) Standard areas not me were:

- Site and Safety – 1 (hot water temp)
- Delivery of Safeguards, services, supports – 3 (adequate staffing level not met; supervision requirements not met)

Audits completed in 2024 by Office of Fire Prevention and Control (OFPC) resulted in no SOD's.

2. Mountain Lake Services' Incident Review Committee's *Quarterly Report*

   Mountain Lake Services takes very seriously the issue of reporting and investigating incidents, as defined by OPWDD in the Part 624 Regulations. All staff, regardless of position, are provided with training and information on incidents and allegations of abuse, as well as promoting positive relationships with our individuals' receiving supports and services. Following this initial training, all staff are given an annual refresher on these topics. Where necessary and sometimes following a specific incident, staff or groups of staff are provided

focused information to ensure that all incidents are reported in a clear, concise, and timely manner.

After an incident or allegation of abuse is reported and investigated, an assigned agency investigator, who has been trained and credentialed to perform investigations, produces a written investigation report. This investigation report is submitted to the agency's Incident Review Committee. At each meeting, the initial incidents, investigations, addendums (to the investigations) are carefully reviewed and discussed. Conclusions are examined to determine that they are adequately supported by the information provided in the investigation. Recommendations of both an administrative and clinical nature are also closely examined. The committee may request additional information, sometimes it is gathered while the committee is in session or occasionally through a clarifying memo or addendum afterwards. Once the committee feels that the program has fulfilled its responsibilities, they will close the case. The program must complete documentation that contains all actions taken from recommendations. This provides information to the committee that the program followed through on the recommendations that will be periodically checked during the agency's self-survey process. The minutes of each meeting are carefully documented and all of the information (e.g. initial report, investigation, addendum, minutes) is entered into the OPWDD's Incident Review Management Application (IRMA), an electronic record keeping system. Any trends or significant issues will be identified and discussed. These discussions are reflected in the minutes of each meeting.

The Compliance Officer develops an Quarterly Incident Trend Report that is required by OPWDD's Part 624 Regulations. This report is an aggregate of the year's results, includes trends as compared to previous years/quarters and makes recommendations for training, policies, physical plant, clinical and program services, etc. This report will be shared with the Incident Review Committee, and Executive Management Team and the full Board of Directors.

The Compliance Officer will oversee and coordinate all OPWDD Bureau of Program Certification activities and responses with regard to incidents and incident reporting, including:

- Presenting the Quarterly Incident Trend Report to the agency's Incident Review Committee, the Executive Management Team and the Board of Directors.
- Providing a summary of NYSARC incident indicators to NYSARC's State Office on a quarterly and annual basis.

3. Quality Improvement Reviews by Non-OPWDD Agencies (Example: CQL Accreditation Reviews)

There are a number of external bodies that may also conduct quality related reviews. These include JCHAO, IPRO, etc.

The Director of Quality and Training will oversee and coordinate these external quality related activities and responses, including:

- Ensuring that external survey teams have access to the information and access to the sites that they need and will ensure that Quality Improvement staff assist the survey team during its reviews.
- For all reviews that result in recommendations or findings, the Director of Quality and Training shall coordinate a written response and communicate such findings and response to the Executive Management Team and the Executive Management Team.

In addition, Mountain Lake Services is CQL accredited and uses CQL Basic Assurances as a quality check annually and at the time of re-accreditation. The Data and Planning Officer oversees and coordinates CQL-related activities and responses.

4. Self-Audits

Based on assessment of risk and need, Mountain Lake Services' Quality Improvement staff shall conduct audits on a sample of programs identified as high risk, using *Internal Audit Checklists*. Risk can be assessed based on prior survey results, survey outcomes, staff and management feedback, etc.

Mountain Lake Services' self-survey information will be reported to the Executive Management Team; and summaries of findings reviewed regularly with the Board of Directors. Quality Improvement staff will:

- develop and maintain annual self-auditing schedules, reviewing each service area not less than once per year; with most sites receiving no less than two audits per year.
- identify risk, including but not limited to an aggregate score of < 90% unmet criteria on the agency's *Internal Audit Checklists*;
- sample service documentation for not less than 25% of persons served in each program or service; and,
- develop and maintain *Internal Audit Checklists*, which include, but are not limited to, criteria contained on OPWDD's *Re-certification Checklists* and related guidance.

Quality Improvement staff will be assigned program audit responsibility by the Director of Quality and Training. Programs at greatest risk will be audited at least semi-annually, using Mountain Lake Services' *Internal Audit Checklists*. This self-survey information will be reported to the agency's Executive Management Team and summaries of findings reviewed regularly with the Board of Directors.

Mountain Lake Services' Director of Quality and Training, who oversees Quality Improvement staff and serves as the agency's Corporate Compliance Officer, will oversee and coordinate the self-audit process, including:

- Ensuring that all *Internal Audit Checklists* are updated during the month of January each year to include any new or changed criteria contained on OPWDD's *Re-certification Checklists* and related guidance, as well as any other criteria identified as a result of the agency's quality improvement process throughout the year.
- Providing copies of the latest *Internal Audit Checklists* to Quality Improvement staff, Directors of programs and services and Managers by January 31st of each year. Subsequent versions will be provided as changes and additions arise.

- Quality Improvement staff will be responsible for auditing all certified programs at least annually, using the appropriate *Internal Audit Checklists*. The completed checklists will be distributed to the Director, Manager and Registered Nurse of the program or service within one week of the audit.
- Directors with internal audit findings that indicate deficiencies will:
    - send a plan of corrective action with the completed *Internal Audit Checklists* to the Quality Improvement staff within two weeks of the audit; and,
    - ensure that specific deficiencies are corrected and each element of the corrective action plan is implemented in a timely fashion.
- The Director of Quality and Training will summarize the findings of internal audits for Mountain Lake Services' Executive Management Team semi-annually; and, review at least annually with the Board of Directors no later than the June board meeting of each year.

5. Satisfactions Levels of the People We Support:

Mountain Lake Services shall ascertain feedback regarding satisfaction with agency supports and services from the individuals supported, their family members, guardians and advocates through opinion questionnaires/surveys. The results of such surveys will be reviewed by the Executive Management Team and the Board of Directors; and, used to enhance operations.

The Executive Management Team will gather information about the quality of the services, supports, and resources provided to individuals on an annual basis, including:

The survey identifies areas of success and areas in need of growth for the individual. The information in the completed satisfaction survey is discussed at the planning meeting. Meeting participants develop a plan of activities to ensure continued success and how to address the areas in need of growth.

The Data and Planning Officer shall coordinate the following activities:

- The Executive Management Team and the Data and Planning Officer will develop a satisfaction survey for use throughout the agency to obtain feedback regarding satisfaction with agency supports and services.
- The Data and Planning Officer will distribute the satisfaction survey on an annual basis.
- The Executive Management Team and the Data and Planning Officer will review the satisfaction survey results with the Executive Management Team, Managers and the Board of Directors.
- People we support, their family members and advocates will be provided with contact information on appropriate agency staff/board members for conveying complaints and/or concerns.
    - The Executive Management Team and the Data and Planning Officer will collect information currently provided to people who receive supports and their family members/advocates on how to contact agency personnel and board members with complaints and concerns.

Overall Individual Satisfaction Surveys completed in 2024 resulted in aggregate positivity score of 71.8%. Areas indicated as opportunity for improvement were communicated to the department Director.

6. Satisfaction Levels of our Staff Members:

Mountain Lake Services shall ascertain feedback regarding satisfaction from our employees through opinion questionnaires/surveys. The results of such surveys will be reviewed by the Executive Management Team and Board of Directors; and, used to enhance operations.

The Data and Planning Officer shall coordinate the following activities:

- The Data and Planning Officer in coordination with the Executive Management Team will develop a satisfaction survey for use throughout the agency to obtain feedback from its employees.
- The Data and Planning Officer will distribute the satisfaction survey on an annual basis and review and document the results of the survey.
- The Data and Planning Officer will review the satisfaction survey with the Executive Management Team and the Board of Directors.
- As directed by the Executive Management Team and the Board of Directors, any actions that result from the responses to the survey shall be implemented under the oversight of the Executive Management Team.

Mountain Lake Services conducted an Employee Satisfaction survey in 2024. Overall, the survey resulted in an aggregate positivity score of 86.8%. Areas identified as opportunities for improvement will be addressed in the coming year.

7. An assessment of the Quality of Life of the People We Support

Description of how the needs, strengths, interests and aspirations of the person are being met through individualized supports, as well as, individual satisfaction with services. The person's input will be included in the self-survey process.

Mountain Lake Services made a strategic decision in 2013 to become accredited with the Council on Quality and Leadership (CQL). This internationally recognized non-profit focuses organizations serving individuals with disabilities to enhance and provide a robust level of person centered supports that facilitate the achievement of their personal goals and aspirations. In addition, CQL assists organizations in conducting an intensive self-survey process that eventually leads to an accreditation.

The CQL framework is an evidenced based system that includes an extensive data set of reliable and valid measurements of quality of life. This is most clearly demonstrated in the CQL *Personal Outcome Measures* (POM), which are 21 areas that are determined by the individual as to whether they are achieving their desired goals and whether the organization is providing the necessary supports. Most recently, OPWDD announced its intention to use the 21 Outcome Measures as part of its analytics in measuring quality.

The *Personal Outcome Measures* are categorized into five groups: My Human Security, My Community, My Relationships, My Choices and My Goals.

- My Human Security focuses on the individual evaluating his/her health, safety, freedom from abuse, rights, continuity and respect.
- My Community focuses on how and with whom people interact in their community.
- My Relationships focuses on the people that are important to them such as natural supports and friends, as well as any social roles they have.
- My Choices focuses on where they live, work and the services they choose.
- My Goals focuses on the goals they have, are working on and if they have achieved any of their goals.

The Personal Outcome Measures are relatively simple and straightforward but contain the characteristics that are very relevant Mountain Lake Services because:

- They are Personal. Each individual determines what quality means for him/herself and the unique life that they lead.
- They are Outcome based. The work is guided by the individual and their expectations, and the results relate very much to what they want and desire.
- They are Measured Differently. The CQL approach addresses the questions of priority and relevance for each person, based on the person's priorities.

The information that is gathered is done so in a highly person-centric way in which a trained interviewer meets with the participant (sometimes several interviews are required). They engage in a semi-structured interview process in order to make an assessment of the 21 data measures and to assist the person in developing focused priority goals. In addition, a person who is very familiar with the individual is also interviewed in order to gather additional information. This process then carefully ascertains what is critically important to the individual and that information is shared with the program planning team. Additional desired outcomes are integrated into the treatment plan that is periodically reviewed and least on a semi-annual basis. It is expected that every two years a re-interview will occur to assess the progress. This is a highly personal way to gather information and ensure that the individual is fully heard and considered and the values and objectives that are most meaningful are included in their goals and plans.

As this process unfolds, Mountain Lake Services will obtain data on whether individuals served in our programs are reaching their aspired goals and if they have the necessary supports. The data gathered through the CQL POM interviews will be analyzed periodically and presented at least once a year to the Executive Management Team of the Board of Directors. When the information is aggregated, it will tell an organizational story as to what additional steps may be needed to improve the quality of services, whether it is in the area of training or supervision, access, actual services, etc.

The data will be collected, analyzed for trends and identify areas that require capacity building. Through these efforts, it is anticipated that the follow up will result in a higher level of both individualized services and participant satisfaction. Some of this work will cause individual staff, various programs, and management to re-evaluate what services are

provided, how they are provided, our expectations and assumptions, as well as our protocols and policies and procedures.

This major undertaking of the CQL *Personal Outcome Measures* will clearly hone our focus on individualized supports, each person's health and safety, their rights, the attainment of their choices and goals, and whether we have in place the appropriate degree of supports. As data will be collected in 21 outcome areas, Mountain Lake Services will begin to be able to measure its progress to achieve the benchmarks set by CQL.

The Data and Planning Officer in coordination with the Executive Management Team shall coordinate the following activities:

- Oversee data on the *Personal Outcome Measure* interviews.
- Aggregate and analyze the POM data.

8. Human Resource Issues such as Staff Retention Rates, OSHA Reportable Injuries, Adequacy of Staffing Levels and Staff Development Programs.

The Executive Management Team of Mountain Lake Services shall have the means to continually assess the adequacy of staffing levels, staff competence and staff performance; and will have a mechanism to address deficiencies. The agency will have a plan for ongoing staff development and training.

The Director of Human Resources shall coordinate the following activities:

- The Director of Human Resources, will maintain a dashboard that provides at-a-glance information on staffing levels (staff vacancies by program site) and that is updated monthly.

- The Director of Human Resources shall provide the Executive Management Team with data related to the number of injuries to staff (OSHA Reportable) while on the job. This data will be analyzed by the Executive Management Team and the Executive Management Team on an annual basis to develop recommendations. Additionally, this information will be submitted to NYSARC, Inc. annually.

- The Director of Quality and Training will update the procedure for ongoing staff development and training annually that includes competency-based training on the following from The Council on Quality and Leadership Measures 2005 *Basic Assurances* and that meets the requirements included in the OPWDD regulations, including:
    - For the Human Rights Committee;
    - To support people's families and friends to communicate with them or otherwise keep in contact and maintain relationships;
    - To prohibit and prevent abuse, neglect, mistreatment, and exploitation;
    - On specific supports, services, policies, procedures, and/or person-directed plans when staff competency is identified as a potential or causal factor;

- When potential underreporting of allegations of abuse, neglect, mistreatment, and exploitation is identified;
- On conduct an investigation for investigators;
- To recognize and respond to people experiencing medical emergencies;
- For direct-contact staff in First Aid, CPR, and general medication training, including how to recognize harmful side effects;
- That is based on input from support staff, input from people supported, and the results of internal and external findings;
- That is based on adult learning theory that includes mentoring, on the job support and personal development planning; and
- That is shaped by the support needs of individuals and includes training in skills and abilities needed to implement people's plans.

- The Quality and Training staff, will maintain reports that provide at-a-glance information on staff competence (names/work sites of staff who have not completed new employee orientation, names/work sites of direct-support staff who do not have medication certification, and names/work sites of direct-support staff who have outdated CPR, First Aid, and SCIP-R training) and that is updated daily. (Reference: 14 NYCRR Part 633.8 Training of Employees)

- The Director of Human Resources, will maintain reports that provide at-a-glance information on staff performance (names/work sites of staff who have not had a performance evaluation within 12 months of the previous performance evaluation) and that is updated daily.

9. Board Governance and Review with Attestation of Quality Improvement Plan:

➢ Board review of the agency's programs and services to ensure conformity with the Mountain Lake Services' *Mission Statement*.

➢ Board participation on the Incident Review Committee for incident review.

➢ Board visits to program sites, per guidelines for announced and unannounced visits.

➢ Board analysis of the agency's self-surveys and regulatory surveys to identify agency or program specific trends.

➢ Board awareness of State or Federal regulatory authority's communications regarding deficiencies in any of the Mountain Lake Services programs or operations.

➢ Board assurance that the Executive Management Team has the means to continually assess the adequacy of staffing levels, staff competence and staff performance with a mechanism to address deficiencies.

➢ Board assurance that the agency has a plan for ongoing staff development and training.

➢ Board assurance that expectations for ethical conduct be communicated and reinforced for all Mountain Lake Services employees, volunteers, and Board members.

➢ Board assurance that agency practices will encourage the development and expression of self-advocacy by the people receiving supports and services; and, assurance that a process is in place for self-advocates to provide input to the agency, practices and governance.

The Director of Quality and Training, who oversees Quality Improvement staff.

- The Director of Quality and Training will send a copy of the *Quality Improvement Plan* and a Board Resolution adopting the plan to the NYSARC's State Office every three years by the end of first quarter.
- Mountain Lake Services shall have a *Mission Statement*. The Board shall review at least annually the performance of the agency's programs and services to determine that there is congruence between the *Mission Statement*, the NYSARC *Mission Statement* and agency operations.
- Ensure that Board member participation on the Incident Review Committee, which is required by regulations, is completed. The Director of Quality and Training will finalize draft incident management procedures, specifically incident management procedures regarding individuals receiving services.
- Board members will have regular access to program sites and individuals receiving services through both announced and unannounced visits.
    - There shall be a committee developed to oversee the practice of Board members visiting sites periodically using visitation survey tools developed by the agency to document results. Announced and unannounced visits to program sites will be mentioned at board meetings by board members and included in the board minutes.
    - The board will develop a tentative schedule for visits.
    - Special events at program sites or elsewhere that include individuals receiving services will continue to be announced at board meetings and included in the minutes.
    - The Board of Directors shall be active in observing the programs and residences in the agency.
- The Director of Quality and Training will maintain compliance policies to reflect current practice of including copies of external surveys and other communication from regulatory authorities regarding deficient practices in packets for board meetings.
- The Director of Quality and Training will summarize for the Board of Directors the findings at least annually of the performance of the agency's programs and services on internal audits and external surveys from regulatory agencies.
- The Director of Quality and Training will provide the Incident Review Committee *Quarterly Report*, which contains an analysis of trends for incidents, to the Board of Directors. The results of the analysis will be shared with the Board and the information used to improve performance.

- The Executive Director shall provide a quarterly summary to the Board related to the adequacy of staffing levels and reasons for staff leaving employment.
- The agency will specify the ways in which expectations for ethical conduct will be communicated and reinforced for all Mountain Lake Services' employees, volunteers, and Board members. The Corporate Compliance Committee will update procedures for each of the standards of conduct each year, as needed. The Executive Director shall provide an overview of the expectations and procedures to the Board on an annual basis.
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IV. NYSARC Quality Indicators

To assess quality of the entire organization, Chapters will periodically provide information to NYSARC. This information, captured in three areas known as Quality Indicators are as follows: Statements of Deficiencies, Incidents, and General Program and Operations. The Director of Human Resources will ensure that Mountain Lake Services' data is submitted and reflects NYSARC's quarterly requests. An example of specific data points is as follows:

General Program and Operation

1. Total number of full/part-time employees
2. Total number of unduplicated individuals served in OPWDD programs only
3. Total number of individuals residing in IRAs
4. Total number of full/part-time employees that have exited employment
5. Total number of vacant FTE DSP positions
6. Total number of budgeted FTE DSP positions
7. Total number of vacant Frontline Management positions
8. Total number of budgeted Frontline Management positions
9. Total number of Frontline Management employees
10. Total number of Frontline Management employees that have exited the position
11. Total number of Emergency Room (ER) visits for individuals residing in IRAs

Statements of Deficiency

1. Total number of OPWDD Bureau of Program Certification (BPC) surveys
2. Total number of OPWDD Bureau of Program Certification surveys resulting in a formal Plan of Corrective Action (POCA)
3. Total number of Office of Fire Prevention and Control (OFPC) surveys
4. Total number of Office of Fire Prevention and Control (OFPC) surveys resulting in a formal Plan of Corrective Action (POCA)

Incidents

1. Total number of substantiated investigations of Reportable Incidents – Abuse / Neglect

Annual Indicators

1. Total number of staff-related injuries (OSHA Defined)
2. Total number of unduplicated individuals served in all programs
3. Total number of unduplicated individuals ages 18-65 served in all programs
4. Total number of participants gainfully/competitively employed due to agency supports
5. Total number of 45 to 60-day letters received
6. Total number of Reportable Incidents – Abuse / Neglect (14 NYCRR Part 624)
7. Total number of injuries to individuals (14 NYCRR Part 624)